Health Professions Council of South Africa

Form 57 DENT

MEDICAL AND DENTAL PROFESSIONS BOARD

CERTIFICATE RELATING TO TRAINING IN SPECIALITIES
(ONLY APPLICABLE TO EDUCATION AND TRAINING OBTAINED IN SOUTH AFRICA)

DP .....

NAME OF HOSPITAL: ..... **NAME OF UNIVERSITY:** .....

NAME OF DENTIST: ..... **REGISTERED QUALIFICATIONS:** .....

Post Occupied, e.g. Registrar (indicate if not full-time)	Appointment No. (Post number)	Department or Division	Period in each Department or Division	
			From	To
A.			*dd / mm / year*	*dd / mm / year*
B.			*dd / mm / year*	*dd / mm / year*
C.			*dd / mm / year*	*dd / mm / year*
D.			*dd / mm / year*	*dd / mm / year*

Certified correct and we, the undersigned, declare that post(s) ..... (state which of A, B, C, etc.) is/are training post(s) of the Faculty.

Signed: ..... **Signed:** ..... **Signed:** .....

Superintendent of Hospital or Dental Head of Service Authority

Head of Academic Department

Dean: Faculty of Dentistry

Date: ..... **Date:** ..... **Date:** .....

UNIVERSITY DATE STAMP

NB: Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.